Iowa General Assembly

2009 Committee Briefings

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ADULT MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICE SYSTEM STAKEHOLDER TASK FORCE WORK GROUP

Meeting Dates: November 18, 2009 | November 4, 2009 | October 21, 2009 | October 7, 2009 | September 23, 2009 | August 26, 2009

Purpose. *This compilation of briefings on legislative interim committee meetings and other meetings and topics of interest to the Iowa General Assembly, written by the Legal Services Division staff of the nonpartisan Legislative Services Agency, describes committee activities or topics. The briefings were originally distributed in the Iowa Legislative Interim Calendar and Briefing. Official minutes, reports, and other detailed information concerning the committee or topic addressed by a briefing can be obtained from the committee's Internet page listed above, from the Iowa General Assembly's Internet page at http://www.legis.state.ia.us/index.html, or from the agency connected with the meeting or topic described.*

ADULT MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES (MH/DD) STAKEHOLDER TASK FORCE

November 18, 2009

Background. The legislation, (2009 Iowa Acts, H.F. 811 Sec. 56) requires the chairpersons (Senator Jack Hatch and Representative Lisa Heddens) to consult with the ranking members (Senator David Johnson and Representative Dave Heaton) of the Joint Appropriations Subcommittee on Health and Human Services in appointing a task force of stakeholders for the 2009 Legislative Interim to address both funding and services issues associated with the service system administered by counties for adult mental health and developmental disabilities services and report recommendations to the Governor and the General Assembly for action during the 2010 Legislative Session. Due to the current budget situation and funding limitations, the chairpersons and ranking members asked the members of the Joint Subcommittee, particularly those who served on the two related subcommittees during the 2009 Legislative Session, to serve as the task force and hold one meeting during the late fall to receive recommendations from a stakeholder workgroup, formed and facilitated by legislative staff, to develop materials and options and receive input from those interested in MH/DD services for discussion and review at the task force meeting.

Membership. Membership of the stakeholder workgroup consists of two provider representatives, three representatives of the Iowa State Association of Counties (ISAC), three representatives of the Department of Human Services (DHS), three representatives of consumers/advocates (an additional consumer joined the workgroup at the September 23, 2009 meeting), and staff representing the House and Senate Democrat and Republican caucuses and nonpartisan staff. Legislators who are members of the task force, as well as those with an interest in the stakeholder workgroup were invited to attend the stakeholder meetings.

Shift State/County Financing of MH/DD Services. Jennifer Vermeer, Medicaid Director, reviewed an option for the financing of MH/DD services. Currently the counties are responsible for the nonfederal share for certain Medicaid services and for services to non-Medicaid eligible individuals including costs for intermediate care facilities for persons with mental retardation (ICFMRs). The Medicaid waiver services which include services for persons with mental retardation, habilitation, targeted case management, and services provided by the state resource centers and the mental health institutes (MHI). In FY2008-2009, the nonfederal share paid by counties for the Medicaid services was $162.5 million. Counties receive state funding through various MH/DD funding pools to pay for both the nonfederal share for Medicaid services and costs of non-Medicaid services. Due to funding under the federal American Recovery and Reinvestment Act of 2009 (ARRA), the Medicaid nonfederal share amount for both the state and counties has been reduced for fiscal years 2008-2009 through 2010-2011, but as ARRA funds drastically decline and are eliminated in FY2010-2011, there will be a funding challenge or "cliff" effect to address. As more services have become available through Medicaid, county Medicaid costs have grown both at a faster rate than the state payments to counties and county property tax revenues due to the dollar amount cap on the property tax revenues. Currently, Medicaid billings to counties are virtually the same amount as the state appropriations to counties for MH/DD funding, but Medicaid is projected to continue growing. In addressing the increasing responsibility to counties for the nonfederal share for

Medicaid, one option is to phase out the county obligation to pay the nonfederal share and the state payments for MH/DD funding. This could be structured so that the Medicaid match is phased down more quickly than the state payments to counties in order to reduce the ARRA cliff coming in FY2010-2011. This approach moves the burden of the growing costs of Medicaid on the state, providing a long-term financing strategy while addressing short-term county shortfalls.

Discussion of Option. County representative, Craig Wood, agreed in principle with the option for the long-term, but noted that if counties are going to rely totally on property taxes for MH/DD costs, the dollar cap on the property tax levy also needs to be lifted. He agreed that eliminating the sending of billings and payments in virtually equal amounts back and forth between the state and counties, and reducing the accounting and other administrative costs would be more efficient, and stated his preference for a phase-down approach, which might be structured to eliminate county responsibility for state resource centers, then the MHIs, then the ICF/MRs, and possibly civil commitment costs. He cautioned that policymakers and the Governor need to address the state's responsibility for the Medicaid match especially in light of discussion with federal authorities that the Medicaid waivers must be applied on a statewide basis. County representative, Karen Walters-Crammond, stated that over the years, counties have asked to have services added to Medicaid and this has been a valuable resource. The Medicaid match has become a significant part of county budgets, but counties are concerned with maintaining local decision making if funding is controlled at the state level. Ms. Vermeer responded that the option presented only relates to the funding, but that local decision making through county points of coordination would be maintained regarding such things as the service array provided. Provider representative, Shelly Chandler, expressed concern regarding the feeling of providers being caught in the middle because of the inconsistencies and inequities in provision of services, and the way reimbursement rates are set. The state initially sets the rates for Medicaid services, but some counties then change the rates based on retrospective reporting. Ms. Walters-Crammond noted that rates do vary from county to county and that there is some room for negotiation on rates. Ms. Chandler reiterated the need for consistency in the rules on rate setting.

States' Approaches to Mental Health and Disability Services. Ted Lutterman, Director of Research Analysis, National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. joined the workgroup by phone to discuss state approaches to providing mental health and disability services. The organization published a report, funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA) analyzing how states' mental health systems are organized in 2007, and is just wrapping up the newest version for publication. One of the issues addressed in the 2009 report is changes to state mental hospitals as the result of state budget shortfalls. Over the last fifty years, the number of state mental hospitals and their populations have decreased dramatically. However, while some have closed due to the inefficiencies of old facilities and fewer patients, some states have addressed the decline in other ways. In Ohio, the hospitals combined administrative functions, but remained open. Texas has also taken this approach. Twelve other states are replacing their state hospitals with smaller, modern, more efficient facilities. One reason for building smaller facilities is that federal regulations provide that state-operated facilities with over 16 beds that provide services for adults between 21 and 64 years of age are considered Institutes for Mental Disease (IMD) and are not eligible for reimbursement through Medicaid. Because of this limitation, Minnesota closed its state hospitals and instead built several 16-bed facilities around the state to provide acute psychiatric inpatient services. Some of the new facilities were built on the grounds of the former state hospitals and some have not yet been accredited for Medicaid, but this is the goal. Minnesota also still has traditional and forensic hospital services. The changes took places over a three or four-year period and many of the locations have only opened in the last 18 months. Mr. Lutterman agreed to provide more details regarding the changes.

Bill Gardam, DHS representative, noted that Pennsylvania has also closed the state mental hospital which was a five year process. Rhode Island is currently the only state without a state psychiatric hospital. The state now provides care in a 75-bed unit of its university general hospital. Recently, Mississippi's governor recommended closing its state hospital which provides six crisis units and is considered an IMD.

NASMHPD is holding a meeting in early December and will then have results of a survey of the states asking about the impact of the budget crisis on state mental hospitals, whether they are considering closing them, and other specifics.

Another trend is privatizing state hospital services. Missouri has privatized services in several locations with the goal of making services eligible for Medicaid reimbursement. Mr. Lutterman will provide additional details regarding these changes.

In response to a question regarding the changes in funding for institutional vs. community-based services, Mr. Lutterman responded that in 1981 approximately 66 percent of funding was used for state hospitals, and 20 percent for community-based services. Today, the amounts have reversed and the 70 percent is used for community-based services with 20 percent going toward state hospital services. Community mental health is the growth area. With respect to the effect of federal health care reform and mental health parity on state mental health systems, Mr. Lutterman stated that the reforms might not have much of an impact on adults because many of those seeking care are unemployed. With regard to states changing behavioral health rather than mental health systems, Mr. Lutterman responded that they are surveying states this year regarding how they address autism, the majority of states do not include conditions such as autism, Alzheimer's, or traumatic brain injury in their mental health systems, but over 50

percent of the states are considering combining substance abuse and mental health services.

Wisconsin Services. Sue Lerdal, Legislative Services Agency, Fiscal Division, reported on a telephone survey with a representative in Wisconsin. In Wisconsin, the mental health and developmental disabilities systems are divided. Counties are responsible for providing services to individuals with mental illness and developmental disabilities, as well as individuals with substance abuse issues. Counties support these services through state and federal funds and county property tax revenues. However, Wisconsin is phasing in a managed care system for Medicaid funded services. The system was developed over time by adding additional counties to the system. The counties contribute a maintenance of effort amount to the system and the managed care organization makes the decisions to provide care. The state currently operates two institutes for mental disease. Beginning January 1, 2010, counties will be responsible for paying the nonfederal share of the costs for Medicaid-eligible patients.

Acute Care Task Force Update. Kelley Pennington, DHS, provided an update on the work of the Acute Care Task Force, established in the fall of 2008, to design a set of recommendations for submission to the Mental Health and Disability Services Division of DHS, for cross-system planning and implementation of expanded acute care services. The task force is broad-based in its composition and also received input from over 60 statewide stakeholders. The task force developed guiding principles for an acute care system, and determined that the current system was developed by default, not by design. The task force recommendations are forthcoming in December 2009, but the summary provided by Ms. Pennington, includes several recommendations, crisis stabilization centers for adults and child and adolescent crisis stabilization services; school-based services; jail diversion programs; subacute services; the expanded role of designated community mental health centers; psychiatric emergency room screening; and commitment diversion/Code Chapter 229 revisions. Representative Heaton asked that current data be provided on out-of-home placements of children; what can be done to encourage more individuals to be involved in the workforce for the mental health system; and how the recommendations of the task force apply in the rural areas of the state.

Review of Options for Submission to the Legislative Task Force. The workgroup reviewed a document entitled "MH/DD System Reform Options—Draft List for Discussion on 11/18/09" summarizing near-term and long-term system change options to be presented to the Legislative Task Force for consideration. The following elements were discussed:

- The workgroup had previously approved the system transformation values and principles outlined in the strategic plan undertaken by DHS.
- The workgroup discussed the funding distribution formula options and had previously approved the option of disregarding the federal stimulus amount during the time that such funds are available (designated as II(A). In discussion of three other funding formula options the workgroup agreed to eliminate the option relating to averaging the ending balances from the two latest fiscal years, supported the option to allow unused risk pool funding to be used to reduce the waiting lists for state payment program services, noting it is also supported by the Mental Health, Mental Retardation, Developmental Disability, and Brain Injury (MH/MR/DD/BI) Commission, and supported the option authorizing counties to return state funding that would cause an excess ending balance.
- The workgroup discussed the near-system change options identified as the highest priorities in an earlier meeting as well as other options. The workgroup discussed the difference between the option for developing a case rate approach for funding distribution and another option to develop and implement a statewide management plan for MH/DD adult services based on functional assessments and distribute funding through caseload-based budgets. It was determined that the first relates to distribution of funds to the county from the state, and the other relates to distribution of funds by counties for services to individuals.
- The members also discussed the option to reduce the amount of paperwork for Medicaid funded programs. While much of the paperwork is required by federal regulation, the members determined that conversations should continue to work together to improve efficiencies in this area, maximize flexibility, and provide additional education and training for those submitting the paperwork.
- County representative, Patty Erickson-Puttman, expressed that she did not support the higher priority option to shift a county dollar cap to a rate cap because this increases taxes and perpetuates the inequities between the counties. Mr. Wood noted that ISAC supports the shift to a county state cap. He noted that if the counties agree to allow the state to assume the costs of the Medicaid services and counties have to provide funding for this, the counties will not agree to it if there is not a standard levy. Currently, the levy amounts range from 24 cents per $1,000 of property value to $2.80 per $1,000 of property value. Ms. Walters-Crammond suggested that no one option is the answer and that a more comprehensive plan is needed going forward to provide more consistency, equity, and access to services.

Vote on Prioritization of Options. Each nonlegislative member was provided with eight "voting" stickers to identify preferences among 20 possible options. The workgroup voted on prioritization of the options reviewed and further discussed those provisions receiving six or more votes. Those receiving six or more votes include (numbers used correspond to the items list under part II-B of the draft options list):

#1 Have the courts assume the costs of mental health commitments instead of counties. (9 votes)

#2. Have the state pay for all institutional costs with no county match. (9 votes.)

#6. Regionalize certain community-based services to improve the system and avoid the use of more expensive services. (8 votes)

#7. Develop and implement a statewide management plan for MH/DD adult services based on functional assessments and distribute funding through caseload-based budgets administered by the counties or county regions. (6 votes)

#9. Address the disparity between the reimbursement rates paid for private intermediate care facilities for persons with mental retardation (ICFMR) level of care versus the state resource center ICFMRs. (6 votes)

#15. State assumption of all Medicaid nonfederal share costs. (15 votes)

Discussion of Priorities. During discussion of the highest priority options, it was suggested that when combined with the previously approved three high priority options there would be nine options, which is too many for a discussion. With further discussion, the workgroup determined that items #1, #2, and #15 could be combined to reflect the concept of state assumption of certain costs from counties, and then lettering #1, #2, and #15 as a, b, and c under this general concept.

The workgroup agreed that item #7 should be rewritten as a pilot option and that item #9 should be eliminated as a priority with only six votes.

Public Poll on Mental Health. Mr. Wood distributed a recent Des Moines Register poll regarding state government budget cuts in which 44 percent of those polled responded that mental health services should be spared from state budget cuts.

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ADULT MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES (MH/DD) STAKEHOLDER TASK FORCE WORKGROUP

November 4, 2009

Background. The legislation (2009 Iowa Acts, H.F. 811 Sec. 56) requires the chairpersons (Senator Jack Hatch and Representative Lisa Heddens) to consult with the ranking members (Senator David Johnson and Representative Dave Heaton) of the Joint Appropriations Subcommittee on Health and Human Services in appointing a task force of stakeholders for the 2009 Legislative Interim to address both funding and services issues associated with the service system administered by counties for adult mental health and developmental disabilities services and report recommendations to the Governor and the General Assembly for action during the 2010 Legislative Session. Due to the current budget situation and funding limitations, the chairpersons and ranking members asked the members of the joint subcommittee, particularly those who served on the two related subcommittees during the 2009 Session, to serve as the task force and hold one meeting during the late fall to receive recommendations from a stakeholder workgroup, formed and facilitated by legislative staff, to develop materials and options and receive input from those interested in MH/DD services for discussion and review at the task force meeting.

Membership. Membership of the stakeholder workgroup consists of two provider representatives, three representatives of the Iowa State Association of Counties (ISAC), three representatives of the Department of Human Services (DHS), three representatives of consumers/advocates (an additional consumer joined the workgroup at the September 23, 2009, meeting), and staff representing the House and Senate Democrat and Republican caucuses and nonpartisan staff. Legislators who are members of the task force as well as those with an interest in the stakeholder workgroup were invited to attend the stakeholder meetings.

Future Meetings and Workgroup Process. Due to budget issues, the shortened session timeframe, and scheduling conflicts, the Workgroup will hold only one more meeting on November 18, 2009, and the December 2, 2009, meeting of the legislator task force to review the recommendations of the workgroup will be canceled and rescheduled for the first week of the legislative session. The final meeting on November 18, 2009, will be used to prioritize both short-term and long-term recommendations to the legislator task force. Members were asked to formulate the long-term recommendations into pilot programs or other more concrete proposals as a means of bridging the gap between the short-term and long-term changes to the system. During the period between the final workgroup meeting and the legislator task force meeting, staff will circulate the draft report of the workgroup for final approval.

Potential Recommendation Areas. Members suggested several areas for recommendations to consider for inclusion in the final report. One is reviewing service systems in other states, possibly Wisconsin, Minnesota, Michigan and others, to determine how best to establish an intermediate level of care. The review should include how these other states resolve the issue of providing higher levels of care without conflicting with regulatory standards. Another issue is

how to address the workforce infrastructure in order to provide sufficient professionals in the mental health system. Another suggestion is developing a proposal based on a white paper developed by Dr. Michael Flaum, portions of which have been submitted as legislative bill drafts in the past.

Data Reports

Mr. Jim Overland, DHS, reviewed various data items compiled at the request of the workgroup.

- **Mandated Services Listing.** The first data item reviewed is a table demonstrating mandated services using the county charts of accounts. The table provides information based on county charts of accounts codes and diagnosis and highlights those services considered mandatory. "Mandated" includes services that are required by law, under the Medicaid program such as those for waiver services or habilitation, or under commitment provisions. Mr. Craig Wood suggested that the document could be viewed as the listing of "core services." By also requiring those that are not currently mandated, this would move all counties to the same level of provision of services, even though this would also increase cost. Members who had discrepancies with the information provided in the document were directed to contact Mr. Overland to discuss any changes, and a new document will be provided to the workgroup if changes are necessary.
- **Mandated Services Budget Impact.** The second document is a pie chart demonstrating the portions of county budget expenditures for mandated and nonmandated services. For 2007, mandated services comprised 56 percent of these expenditures.
- **Service Expenditures.** The third document is a series of pie charts and bar graphs demonstrating county expenditures for behavioral health services for each year from 2001 through 2008 by service type. The portion coded as "all other" includes nonmandated services, commitment costs, and non-Medicaid services. Ms. Jennifer Vermeer, Medicaid Director, explained that the Adult Rehabilitation Option (ARO) was replaced with habilitation under the Medicaid program due to Medicaid regulations that require services provided to be rehabilitative, i.e. that move individuals toward improvement rather than merely providing a maintenance level of care. By replacing the service, the state reduced the risk of being subject to repayment of funds for providing noncompliant services.
- The fourth document is a large chart that demonstrates the FY 2007-2008 Medicaid Behavioral Health and Mental Health and Disability Services numbers recipients served by county, based on county of legal residence. Mr. Overland highlighted two columns: one demonstrating total unduplicated number of individuals receiving Medicaid behavioral health services, and the overall total which in addition to Medicaid behavioral health services, includes Mental Health Institute (MHI) and State Payment Program services. The total number of adults receiving each service by county is highlighted in red columns.
- The fifth group of documents consists of four maps showing the distribution of individuals who received services in FY 2007-2008 among the counties. The first map (shades of green) documents the number of individuals served in the State Payment Program by county of residence. The numbers reflect the number actually paid for in the fiscal year. The second map (blue) demonstrates the population served by county of residence and provides the total county population, the population served by county of residence, and the percentage of the county population served. The third map (light green) demonstrates the population served by county of legal settlement and provides the total county population and the number served by county of legal settlement. The fourth map (shades of red) demonstrates the total number of individuals served in the county and provides the number served and the total county population. This map correlates with the information provided in the large red-colored chart.

Data Discussion. In regard to the third document pie charts, by including more Medicaid services, the counties can initially get fiscal relief by only paying the state/local match portion, but as the service expands to more people, the cost of the match funding outpaces the initial fiscal relief. Ms. Vermeer noted that the pie charts do not demonstrate the large amount of federal funding that is also expended to provide services, and that even though a larger portion of services are moving under the Medicaid program and expenditures are increasing, the increases might have happened notwithstanding involvement of the Medicaid program. In response to a comment that the cost of the same service is more expensive under Medicaid, Ms. Vermeer noted that federal requirements limit flexibility that might otherwise exist. With regard to national health care reform, Ms. Vermeer stated that generally the reforms being proposed should be beneficial for those involved in the behavioral health services system, but the degree of the benefit will be in the details and the state will have to make policy decisions based on these details.

During discussion of the map information, it was noted that the numbers do not provide the specificity of intensity level of the services provided. Additionally, the richness of services in a county does not necessarily correlate with increased utilization of services. The documents only demonstrate public services and do not include services provided by private providers compensated by other than public funds.

Brain Injury Waiver. The first document discussed by Ms. Vermeer provides information regarding the Home and Community-based Services Brain Injury (HCBS BI) waiver waiting list and an analysis of the costs of care associated

with people during their time on the waiting list. Ms. Vermeer provided specifics and noted that there are many variables that come into play for those on the waiting list. While some might go into institutional care, others may find services through funding streams other than Medicaid such as family, the community, or the counties. Calculating the savings that might be realized by serving everyone on the waiting list under the HCBS BI waiver compared with alternatives is not clearly predictable. Additionally, those who are eligible for the waiver may not be eligible for standard Medicaid services due to different eligibility requirements for the two types of services. Comments were made regarding the necessity of providing appropriate services to persons with brain injury in order to properly address needs and reduce costs for inappropriately provided services. Additionally, comments were made regarding changes in coverage of services for persons with brain injury provided through the private insurance market.

Private ICFMRs and State Resource Center ICFMRs. Information concerning reimbursement rates for and services provided by private intermediate care facilities for persons with mental retardation (ICFMR) and the state resource center ICFMRs was presented by Ms. Vermeer, by Ms. Shelly Chandler in her role as Director of the Iowa Association of Community Providers, and by Mr. James Finch, Superintendent, Woodward State Resource Center (SRC). The DHS information indicates that the SRC per diem rate of approximately $600 is roughly double the per diem rate payable for private ICFMR, SRC staffing costs are higher due to compliance with the U.S. Department of Justice consent decree requirements, roughly 74 percent of the cost difference is based on higher spending at SRC for direct care staff and health care, higher union salaries at SRC, and a decreasing census resulting in higher fixed costs per person served.

Ms. Chandler deplored the reimbursement differential, noting that private ICFMRs and SRC ICFMRs have similar requirements for staff qualifications, some private ICFMRs also have union contracts, and both deal with difficult-to-serve and fragile patients. She referred to recent Des Moines Register articles detailing quality issues at the SRCs and described problems and lengthy processes in order to place two difficult patients at an SRC. She opined that while there is much stated interest in shifting toward community-based services, the continuation of the large reimbursement disparity shows that actual priorities do not match the rhetoric.

Mr. Finch outlined the progress made in recent years by Woodward SRC in moving clients to community settings and described a new grant-funded program for the SRC to provide statewide mobile crisis intervention team services to community-based programs.

Options For Accepting Allowed Growth Funding. The workgroup discussed an e-mail from Marv Julius, Story County. Mr. Julius suggested an option to allow counties to refuse part or all of a state allocation that might cause a high ending balance in the succeeding fiscal year in order to eliminate the cycle of high and low allocation years, with the refused dollars being reallocated. Members discussed the concept and recommended the option be more fully evaluated, possibly varying the date by which the funds would have to be rejected.

Citizens' Aide/Ombudsman Suggestions. Ms. Linda Brundeis presented suggestions regarding the services system in two areas: the mental health commitment process and the mental health courts/jail diversion program. Suggestions include:

- Legislatively mandating communication and collaboration between the parties in the system which may require changes in the law to clarify who is responsible for various roles in the commitment process and to encourage consistency across the state.
- Establishing a pilot project or mandate the use of community mental health centers (CMHCs) to pre-evaluate persons for mental illness prior to court-ordered commitment.
- Using the MHIs for subacute care.
- Mandating notification of law enforcement by a hospital or other medical provider prior to a patient's release, if the patient was delivered to the provider by law enforcement for mental health-related concerns.
- Consider pilot projects using federal grants to establish mental health courts and jail diversion programs. Grants would be sought by an existing entity such as the MHMRDDBI Commission.
- Review a recently released guide on mental health courts for guidance.
- Review Code Chapter 230A and consider the role of CMHCs in providing mental health services to jails.

Across-the-board Budget Reductions. Members' comments regarding the recent across-the-board budget reductions ordered by Governor Chet Culver included:

- Support of providers must be considered in any discussion of financing the system.
- Gratefully, the budget reductions this year did not seem to fall as disproportionately on persons with disabilities as in previous budget reductions. However, it is a serious situation that must be monitored.
- It is important to work with the department in streamlining the system to prevent unnecessary additional work for providers.
- Legislation may be necessary to transfer funding between funding streams to meet specific needs such as the waiting list.

- Legislators should review the private insurance market practice of characterizing services for a brain injury under the coverage for mental health rather than as a physical injury with residual mental health issues.

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ADULT MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES (MH/DD) STAKEHOLDER TASK FORCE WORKGROUP

October 21, 2009

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Procedural Business. The workgroup convened its fourth meeting at 1:30 p.m. and adjourned at 4:00 p.m. The members approved the briefing of the October 7, 2009, meeting.

Presentation By Dr. Michael Flaum. Dr. Michael Flaum, Director, Iowa Consortium for Mental Health, University of Iowa, Carver College of Medicine, presented information regarding options for cost savings through regionalization of community-based services. Dr. Flaum's power point presentation is available on the workgroup website. Dr. Flaum wears many hats including those of a member of a university community, a DHS/MHDS contractor, and a clinician. He cautioned that no one knows how to completely fix the system, but everyone can acknowledge that there are inefficiencies in the system that have resulted from instituting quick fixes rather than structural changes. The money that is in the system needs to be used correctly, and even though there have been a number of changes in the mental health arena in just the last 50 years, in Iowa and nationally, the same structure and system is still being used to address mental illness. Quick fixes are sometimes necessary, Dr. Flaum said, but it is important to continue the two missions of short-term strategies and long-term structural reforms.

Structural reform requires having a vision and moving toward it, having data to support the vision, and investing in the effort. Reestablishing the Division of Mental Health and Disability Services (MHDS) at the state level in 2006 was a big improvement, but the system is still under-resourced. The system is overly reliant on emergency rooms and acute care hospitals as the locus of care, and the majority of patients could be better served elsewhere. The people in the hospitals are generally those in crisis and not necessarily those with severe mental illness. They may have multiple co-occurring problems such as substance abuse, criminal justice issues, homelessness, or unemployment. These issues cause them to "hit the wall" and they go to the emergency room and are then in the system. There is a functional, as opposed to a structural, hospital bed shortage because this level of care is used as an intake step for everyone. Meaningful structural reform is needed to provide more appropriate care through an array of services, such as crisis stabilization units, access centers, and assertive community treatment, not necessarily in every county but on a reasonably accessible basis.

Data needs include estimates of expected prevalence of mental illness by severity, expected utilization of mental health services by provider type, and trends over time. Even though mental illness prevalence rates have not increased dramatically over decades, the number of individuals seeking treatment has increased. If this trend continues, preparations today may not be relevant in the future.

The 1965 "Mental Health Planning in Iowa" study was a federally funded effort that resulted in much of the structure, including the bricks and mortar, existing in the mental health system today. This type of planning is critical. Short-term fixes are needed to address budget issues, but investment in long-term planning is also necessary for structural reform.

The DHS Mental Health Planning Committee is working on tracking data regarding needs, utilization, length of stay, and other factors that will help with determining costs based on actual need. More collaboration between levels of care, such as hospitals and community mental health centers, is necessary to providing appropriate care.

Statewide Management Plan and Funding Strategy. Mr. Brad Leckrone, Wright County Central Point of Coordination (CPC); Mr. John Grush, Boone County CPC; and Mr. Russell Wood, Franklin County CPC, presented a plan for a needs-based funding system. The plan is available at the workgroup website.

The plan includes both management and funding strategies. The plan calls for the development of a statewide management plan for MH/DD adult services to provide direction and standards to counties and regions, while retaining local decision-making to promote flexibility and efficiency. Eligible individuals would be assessed utilizing one of two assessment tools based on type of disability, the Supports Intensity Scale (SIS) for persons with mental retardation, developmental disabilities, or brain injury (MR/DD/BI); or the Level of Care Utilization system (LOCUS) for persons with chronic mental illness (CMI). An individual's budget allocation would be determined by the needs assessment. Individuals and their team/representative would choose what supports to purchase based on the budget and identified needs. Additionally, using the Community Service Network, counties and regions would be able to submit and access real-time data. Under the plan, the current funding formula is eliminated and counties or regions instead submit needs-based budgets based on individual assessed needs, historical nonassessed needs, and administrative expenses. Counties with services unique to their county would include these in their budgets. Under the plan, counties would levy their maximum based on standardized levy rates to establish funding equity, but some counties would not have sufficient funding. All current state funding from growth, community services, property tax relief, and risk pool funding streams would be pooled in a State Mental Health Fund and allocated based on the county budgets developed by the counties, not on a funding formula. If pooled funding was not adequate, statewide waiting lists could be implemented. Options for establishment of such waiting lists would include prioritizing risks through reductions in individualized budgets; reducing the impact on persons with higher assessed needs; or utilizing waiver slots on a statewide basis. The plan addresses waiting lists and waiver slots by utilizing a statewide rather than county or regional basis; resolves legal settlement by allocating pooled funds based on assessed needs and to the county or region where the individual resides; and addresses system inequities by moving from a concept of core services to one of objectively assessed needs. The proposal moves the system toward focusing on individuals and funding individual needs, and also would result in creative solutions to develop community capacity. Ongoing training would be essential to the assessment process.

County Levy Rate Cap. Ms. Karen Walters-Crammond, Polk County CPC Office, reviewed the proposal previously presented regarding moving from a county dollar cap to a rate cap for the mental health property tax levy. Ms. Walters-Crammond reviewed the history of the dollar amount freeze and noted that due to the freeze, any additional increase in the cost of the service system has been placed on the state to fund, and this funding has not been sufficient. She noted that had the levy rate in effect been frozen instead of the dollar amount, counties could have levied approximately $50 million more in 2009. Overall, maximum levy rates have declined under the dollar amount freeze. Some options for change include allowing a temporary supplemental levy authority for county mental health funds up to a maximum levy, pending any longer-term solution; establishing a smaller range of allowable levy rates to provide more equity across the state (currently, the levies range from $0.24 to $2.76); and allocating state dollars based on services provided and the individuals served utilizing incentives for evidence-based practices and core values. Mr. Craig Wood, Administrator, Linn County CPC, added that the change in levy would not be considered a tax increase because any increase in the levy would be dependent on a vote of each county board of supervisors, and the General Assembly would merely be providing the option to counties. Others expressed concern about overcoming lobbying efforts against a change in the levy amount.

State Investment in Community Capacity. Mr. Bob Bacon, Center for Disabilities and Development at the University of Iowa, discussed the previously presented option for building community capacity. He noted that state investment will be needed to provide the changes, but that some of this can be done by redirecting resources through strategic grant-seeking and through better local coordination and in-kind matching. The Division of MHDS is working on an integrated plan to outline how to change Iowa's system to support anyone with a disability. Mr. Bacon suggested that, in addition, a process is needed to assure steady progress in implementing Iowa's integrated mental health and disability services plan. This could be in the form of an ongoing legislatively mandated workgroup of stakeholders to continually monitor the plan's implementation and advise on its strategic financing. Mr. Bacon listed various issues that are being addressed in building community capacity but noted that one area that is not currently being addressed is the waiting list for the Home and Community-Based Services rent subsidy. Mr. Bacon stated that building community capacity is an investment, but it is difficult to determine the return on investment in the future. Investing in community capacity now can save avoidable costs in the future by diverting people from inappropriate or higher levels of care.

Case-Rate Approach. Mr. Craig Wood and Ms. Walters-Crammond discussed the option, previously presented, of using a case-rate approach for distributing funding to counties. Ms. Walters-Crammond noted that, as with school aid, the key is getting the numbers right. This approach would require additional research to more accurately predict costs and needs and to determine what services communities want to fund. In response to a question regarding the 2003

work on case rates, Mr. Bill Gardam, MHDS, DHS, noted that the previous division administrator was not supportive of the concept at the time and decided to go in a different direction, while other members noted issues with timing, data availability, and staff resources.

Sliding Scale Funding Distribution Formula. Mr. Jess Benson, Legislative Services Agency (LSA), Fiscal Division; Ms. Julie Jetter, DHS, and Ms. Robyn Wilson, DHS, discussed the results of analyzing the option of using a sliding scale to distribute funding to counties with ending balances of below zero through 15 percent. The presenters noted that regardless of the numbers used, there would still be counties that would not show improvement. The members discussed the option of disregarding the increased Federal Medical Assistance Percentages provided under the American Recovery and Reinvestment Act of 2009 in distributing the funding. Members also discussed whether the fund balance used in the calculation should be the fund balance for two years prior or another option. Ms. Linda Hinton, ISAC, cautioned that any time the base year is changed, it causes disruption. The two-year prior balance is helpful to legislators to see what the effect will be on their counties. It is difficult during the legislative session to make decisions based on projected rather than actual balances.

Other Business. Ms. Linda Brundies, Citizens' Aide/Ombudsman presented a document summarizing a survey of central point of coordination administrators regarding civil commitment and placement issues. Members discussed the need for everyone involved, including the judicial branch, hospitals, and community mental health centers, to communicate about the process.

Mr. Benson noted that the proposed departmental budget reductions are preliminary, pending the Governor's response, but there would be time allocated at the next workgroup meeting to discuss the reductions. Mr. Craig Wood proposed options to find money elsewhere to avoid budget reductions in the human services area, including eliminating certain tax credits, reducing state employee salaries by 5 percent rather than laying off employees, and using the roads budget to pay for people rather than roads.

Members discussed the need for solid data infrastructure, assessment tools, and a plan that endures beyond changes in stakeholders. Members also discussed the need for utilizing appropriate services to reduce costs, including savings that could be realized by using appropriate services for persons with brain injury.

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Internet Page: http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=502

ADULT MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES (MH/DD) STAKEHOLDER TASK FORCE WORKGROUP

October 7, 2009

Background. The legislation (2009 Iowa Acts, H.F. 811, Sec. 56) requires the co-chairpersons (Senator Jack Hatch and Representative Lisa Heddens) to consult with the ranking members of the Joint Appropriations Subcommittee on Health and Human Services (Senator David Johnson and Representative Dave Heaton) in appointing a task force of stakeholders for the 2009 Legislative Interim to address both funding and services issues associated with the service system administered by counties for adult mental health and developmental disabilities services and to report recommendations to the Governor and the General Assembly for action during the 2010 Legislative Session. Due to the current budget situation and funding limitations, the chairpersons and ranking members asked the members of the joint subcommittee, particularly those who served on the two related subcommittees during the 2009 Legislative Session, to serve as the task force and hold one meeting during the late Fall to receive recommendations from a stakeholder workgroup, formed and facilitated by legislative staff, to develop materials and options and receive input from those interested in MH/DD services for discussion and review at the task force meeting.

Membership. Membership of the stakeholder workgroup consists of two provider representatives, three representatives of the Iowa State Association of Counties (ISAC), three representatives of the Department of Human Services (DHS), three representatives of consumers/advocates (an additional consumer joined the workgroup at the September 23, 2009, meeting), and staff representing the House and Senate Democrat and Republican caucuses and nonpartisan staff. Legislators who are members of the task force as well as those with an interest in the stakeholder workgroup were invited to attend the stakeholder meetings.

Overview. At this meeting, workgroup members and others made short presentations on reform options. The workgroup members indicated priorities among the options presented, with the understanding there would be an opportunity for reconsideration of lower priority items at a later meeting. Written materials were included in each presentation that will be posted on the Internet site for the workgroup.

County Service Arrays. Dr. Carl Smith, Professor and Chairperson, Department of Curriculum and Instruction, Iowa State University, discussed his concerns with the workgroup focusing on the immediate problems with funding formulas,

caps, and county balances. He advocated for a greater focus on the county services management plans, the services actually provided, and whether the plans are being successfully implemented. In addition, he offered criteria for determining implementation success and for viewing the service array in terms of services available in each community, regionally (four or five sites), and statewide (using telemedicine or other technology).

County Levy Rate Cap. Ms. Karen Walters-Crammond, Polk County Central Point Coordination (CPC) Office, provided information regarding the cap on the dollar amount counties are permitted to levy for adult MH/DD services, and proposed shifting instead to a levy rate cap. Among reasons offered for change were to make the levy restriction consistent with other levy caps and the lack of sufficient state appropriations to address increased costs. Comparative information was provided regarding the effects of the dollar amount cap on county levy rates from 1998 to 2009, and it was noted that had the levy rate in effect been frozen instead of the dollar amount, counties could have levied approximately $50 million more in 2009. Options offered included allowing temporary authority for a supplemental levy for MH/DD services and using all available state appropriations to narrow the disparity in the current levy rates among counties.

Combine Associated Services. Ms. Teresa Bomhoff, Chairperson, Iowa Mental Health Planning Council, and President, National Alliance on Mental Illness (NAMI) of Greater Des Moines, proposed combining administrative responsibility for mental health treatment, substance abuse treatment, and suicide prevention in one agency, preferably the Department of Public Health (DPH). She explained that 50 percent of persons with mental illness also have substance abuse problems and vice versa and that 90 percent of those who attempt suicide have mental illness. Recently, DPH and DHS have been cooperating in providing training for co-occuring disorders of mental illness and substance abuse. She suggested that combining administrative responsibilities can provide efficiencies, improve outcomes, and be more acceptable to consumers.

State-identified Services. Mr. Craig Wood, Administrator, Linn County CPC, proposed applying a Medicaid-style model to the county MH/DD system in which the state would identify sets of mandated and optional services. He provided examples of potential mandatory services such as home-based services and outpatient mental health treatment. As with the various states participating in Medicaid, different match rates could be established for counties based on relative poverty population percentages or unemployment rates. The county role would be to do eligibility determinations and service authorizations in accordance with state rules and quality assurance requirements. He stressed that unlike health providers in the Medicaid system, providers of MH/DD services have little ability to pass along costs to other patients or clients, so there would need to be a risk pool or other means to address localized funding shortages.

State Investment in Community Capacity. Mr. Bob Bacon, Center for Disabilities and Development at the University of Iowa, proposed including a focus on investments in the capacity of communities to support recovery for persons with mental illness and for inclusion of persons with disabilities in community life. The center's work with the Money-Follows-the-Person Grant, a federally funded effort to support the movement of persons living in Medicaid-supported institutional settings to a community setting, has identified many barriers that can be addressed by systematic development of community capacity. The barriers he identified include various types of behavioral programming and crisis intervention, regular training for direct services staff, availability of low-cost housing, transportation, and a statewide functional assessment system.

Case Rate Approach. Mr. Wood proposed implementation of a case rate approach for distributing funding to counties according to the number of persons served by a county and the intensity of each person's service needs. This approach is based on performing a functional assessment of a person needing services and using the resulting assessment score to identify a case rate for the person based on a matrix. There are variables that need to be addressed, such as higher prevailing wage in some areas of the state, whether the person has family or other "natural" supports that others do not, the need to address county administrative costs and infrastructure development needs, and risk provisions to address unanticipated high-cost needs. Members raised questions concerning the reliability of functional assessments and the role of counties in authorizing Medicaid services.

Legal Settlement Issues. Ms. Walters-Crammond discussed issues connected with Iowa's system of assigning financial responsibility for the costs of a person's services to counties based on a determination of legal settlement. An initial step was implemented on July 1, 2008, to move to more of a residency-based approach by requiring eligibility and services to be determined in accordance with the service management plan of the county of residence. She presented a preliminary data analysis if a change would be implemented to define residency as a person living outside a licensed facility and proposed a number of specific provisions such as shifting to a state funding formula that follows the person.

Priorities. The workgroup identified the following items as having the highest priority for further development:

- Shifting from a county dollar cap on levies to a rate cap
- Working on state investments in community capacity building
- Developing the case rate approach for funding distribution and other measures for distributing funding based upon persons' county of residence rather than legal settlement.

Data. Staff from DHS distributed and discussed several data items developed in response to requests from the workgroup.

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ADULT MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES (MH/DD) STAKEHOLDER TASK FORCE WORKGROUP

September 23, 2009

Background. The legislation (2009 Iowa Act, H.F. 811 Sec. 56) requires the chairpersons (Senator Jack Hatch and Representative Lisa Heddens) to consult with the ranking members (Senator David Johnson and Representative Dave Heaton) of the Joint Appropriations Subcommittee on Health and Human Services in appointing a task force of stakeholders for the 2009 Legislative Interim to address both funding and services issues associated with the service system administered by counties for adult mental health and developmental disabilities services and report recommendations to the Governor and the General Assembly for action during the 2010 Legislative Session. Due to the current budget situation and funding limitations, the chairpersons and ranking members asked the members of the Joint Subcommittee, particularly those who served on the two related subcommittees during the 2009 Session, to serve as the task force and hold one meeting during the late Fall to receive recommendations from a stakeholder work group, formed and facilitated by legislative staff, to develop materials and options and receive input from those interested in MH/DD services for discussion and review at the task force meeting.

Membership. Membership of the stakeholder workgroup consists of two provider representatives, three representatives of the Iowa State Association of Counties (ISAC), three representatives of the Department of Human Services, three representatives of consumers/advocates (an additional consumer joined the workgroup at the September 23, 2009, meeting), and staff representing the House and Senate Democrat and Republican caucuses and nonpartisan staff. Legislators who are members of the task force as well as those with an interest in the stakeholder workgroup were invited to attend the stakeholder meetings.

Overview of Current Allowed Growth Distribution Methodology. Mr. John Pollak, Legislative Services Agency (LSA), Legal Services Division, provided an overview of the allowed growth distribution methodology utilizing a document prepared by Mr. Jay Syverson, formerly with the ISAC. Mr. Pollak cautioned that a federal expert visiting Iowa once noted that you can have a formula that is simple or fair but not both at the same time. *The formula includes specific terminology and reference points including: "fund balance" which refers to the accrual fund balance two years prior to the allocation; "levy" and "rate" which always refer to the current year; and "population" which always is the most recent census estimate.* In order to receive funding, an element of the formula requires counties to meet filing deadlines for annual financial reports which are due annually on December 1 and a COMIS (County Mental Health Management Information System) report which is also due annually on December 1. However, in recent years legislation was passed to legalize the submissions of the few counties that were not able to meet a deadline, and last year the General Assembly enacted legislation to allow the Department of Human Services to approve late submissions.

Mr. Pollak noted that all counties receive state mental health funding through property tax relief moneys (approximately $90 million through a separate funding formula) and may also receive allowed growth funding. He described step one, the initial allocation of allowed growth funding, which is tentatively allocated to counties through four distinct funding pools: community services, allowed growth, per capita, and special appropriations:

- **Community Services.** The community services pool was established in the 1980s to assist counties with improving community services in addition to institutional services. The moneys in this pool are distributed to counties according to a formula of 50 percent based on the latest general population estimate and 50 percent based on the most recent poverty population data. The total amount in this pool (approximately $15.8 million) changes minimally each year, and all counties are eligible for community services funding.
- **Allowed Growth.** This was the first attempt by the state to fund the growth in costs above the dollar amount (not levy rate amount) where county mental health funding was frozen in 1998. This pool is distributed to counties based on the latest general population estimate for each county. The total amount in the pool ($12 million) changes minimally each year and all counties are eligible for allowed growth funding.
- **Per Capita.** The per capita pool was developed in an attempt to address uniformity in spending because levies and spending on services vary greatly from county to county. This pool of funding is distributed based on the latest general population estimate. The total amount in the pool is approximately $38 million, and allocations can vary dramatically each year because only counties that levy 100 percent in the current year and have a fund balance below 25 percent two years prior to the allocation are eligible to receive funding from this pool.
- **Special Appropriation.** This pool was developed a couple of years ago to address the special needs of counties with low fund balances. This pool of approximately $12 million is allocated to counties based on

population and only if the county has a fund balance of 15 percent or less and a levy at either 100 percent of the maximum or at least 90 percent of the maximum with a rate above $2.00 per thousand.

Getting to Step Two—Withholding. In 2001 there was a state funding crisis, but the counties, in general, had ample funding balances. The withholding factor was developed as a mechanism to incentivize counties to levy the maximum amount and spend down their funding balances to make up the difference between what the state was able to allocate (the final allocation) and the total amount of the initial allocation. The withholding factor affects counties that are levying at least 90 percent of the maximum of their levy in the current year and have a fund balance of more than 10 percent one year prior to the allocation. Mr. Pollak explained that the General Assembly has chosen to make the withholding factor a part of the formula rather than appropriating the entire amount for the initial allocation up front because it incentivizes counties to levy closer to the maximum percentage and decrease their fund balances. The way that the appropriation is made each year provides that for the purposes of calculating the allocations, the total appropriation is the allocated amounts.

Step Two—Final Allocation. Step two is the mechanism necessary because of the withholding factor and its objective of getting funding to counties with shortages. Step two begins with the counties' initial allocation of the combined step one amounts (community services, allowed growth, per capita, and special appropriation). Then, based on the percentage of the maximum of the levy a county is levying and the county's fund balance, the county falls into one of four group options:

- **Group 1.** If a county is levying less than 90 percent of its levy or greater than 90 percent of its levy but has a fund balance of greater than 25 percent, the county falls into group 1 and the entire initial allocation amount is withheld.
- **Group 2.** If a county is levying greater than 90 percent of its levy and has a fund balance of less than 5 percent, the county falls into group 2 and receives the initial allocation plus a 3 percent inflation factor.
- **Group 3.** If a county is levying greater than 90 percent of its levy and has a fund balance that is between 5 and 10 percent, the county falls into group 3 and receives its initial allocation plus a 2 percent inflation factor.
- **Group 4.** If a county is levying greater than 90 percent of its levy and has a fund balance that is between 10 percent and 25 percent, the county receives its initial allocation multiplied by a withholding factor. The withholding factor is calculated by dividing the amount of available money by the combined initial allocations of group 4 counties only and then using the resulting percentage (the withhold factor) multiplied by each county's individual allocation to determine the additional amount that each group 4 county receives.
- **Group 4 and "The Ledge".** One additional element of the formula that applies only to counties in group 4 that have fund balances between 10 and 15 percent is called "the ledge." The ledge was developed to insert a degree of fairness and to provide that a county in group 4 with a fund balance between 10 and 15 percent can only lose an amount of money equal to the amount by which its fund balance exceeds 10 percent.

Discussion. Members noted concerns with how the federal American Recovery and Reinvestment Act of 2009 (ARRA) funds will affect ending balances and what will happen when these funds are no longer available. (Approximately $75-80 million is available to counties over a 27-month period ending mid-state fiscal year 2012). The workgroup also discussed the prohibition of reserving ARRA funds in an account. Medicaid Director Jennifer Vermeer explained that the funds are distributed to the counties as federal matching funds for county expenditures, so the result to the counties is a reduction in expenditure of nonfederal matching funds rather than an actual increase in funding that could potentially be reserved.

Short-Term Options Discussion. The workgroup was provided with an initial list of six options that were suggested by members of the workgroup to address short-term changes in the distribution of allowed growth funding and identified positive and negative attributes for each. Options 3 and 6 were clearly the top choices and staff will work on modeling them.

- **Option 1.** Use the county ending balances for FY 2007-2008 instead of updating the ending balances. Since the ending balances currently being used are from two years ago, this would extend the disadvantages to which a large number of counties have been subject.
- **Option 2.** Increase the ending balance percentage by the same amount as the federal stimulus amount to be received by each county in order to hold counties harmless when the federal funding is no longer available. Members expressed concern that there be some provision that this not result in a reduction of services.
- **Option 3.** Disregard the federal stimulus amount to be received by each county. This option was viewed as another way to achieve the objective desired with option 2. It was suggested that this might be the most straight-forward option.
- **Option 4.** Eliminate the 3 percent and 2 percent inflation adjustments, but maintain the ledge for counties with

ending balances between 10 percent and 15 percent. The workgroup discussed that this option, basically removes the inflation adjustments, referred to as "escalators," would probably not result in much change in FY 2010-2011 because two-year-old fund balances are being used and while most fund balances increased, expectations decreased.

- **Option 5.** Distribute the same amounts to qualifying counties in FY 2010-2011 as was distributed in FY 2009-2010; if additional funding is available, distribute this funding based on a new formula. The workgroup discussed that given the economic situation, increased funding would probably not be available and this option, as with option 1, would allow perpetuation of the disadvantages for some counties for an additional year.
- **Option 6.** Eliminate the adjustments of step 2 in the current formula and replace with a sliding scale based on ending balance percentages of negative through 15 percent. The workgroup determined that the percentage level should be 15 percent or less so as to include those with negative funding balances. This option would simplify the formula and would remove the ledge effect, but might be a more long-term solution.
- **Option 7.** Options to address the current formula. This option was developed during discussion. Workgroup members voiced concern about the need to incorporate the idea that consumers should be held harmless from a reduction in services through any change to the formula.
- **Option 8.** Option 2 or 3 plus the requirement of maintaining services.

Other Discussion. The workgroup discussed options such as lifting the dollar amount freeze and instead allowing counties to cap funding at the level of the 1998 levy rate. Mr. Jess Benson, LSA, Fiscal Services Division, referred the workgroup to a document he prepared that demonstrates this scenario. By authorizing counties to cap funding based on the same levy rate that existed in 1998, approximately $50 million in additional funding would be available in the system. Others suggested that even if the dollar cap is lifted and the levy rate used, the formula for distribution would still require changes due to such conditions as low property valuations in some counties. It was suggested that funding cannot be considered in the absence of discussing ways to eliminate the variability among counties in the equity of services. It was determined that while it is necessary to talk about considering changes to the system to make service delivery more equitable, this is a task that is difficult to complete during the legislative session and the more pressing issue is always how to distribute the funds in the current appropriations cycle. The workgroup also discussed how national health care reform might affect mental health system service financing and delivery. Ms. Vermeer commented that even though there have not been specific conversations about mental health, changes that are being discussed with regard to private health care coverage benefit plans and increases in the level at which Medicaid will be made available to adults will change the dynamics of the availability of funding for mental health services. One option that is being considered is allowing states to submit Medicaid state plan amendments to start some of the reforms early in 2011. The workgroup determined that issues regarding the levy rate and federal health care reform should be included in the long-term options list for future consideration.

DHS Comprehensive Plan. Mr. Bill Gardam, DHS Division Administrator, presented the DHS comprehensive plan entitled: "Transforming Iowa's Mental Health and Disability Services System: A Community Discussion." Mr. Gardam addressed the questions of why a plan is needed; why various interests including education, the employment sector, corrections, and veterans services must work together; why the current system is not working; and the goals of the new system. In working on the plan, the department reviewed the many previous reform efforts and gleaned information from the reports of these efforts. They have also had a series of community discussions and have developed principles to guide the transformation. Members supported the idea that DHS had considered past efforts and was moving toward action rather than more study. The workgroup expressed its support of accepting the values and principles expressed in the presentation and the idea of moving forward in a united effort.

County Social Services Pilot Project Overview. Mr. Bob Lincoln, County Social Services Administrator for the pilot project involving Black Hawk, Butler, Cerro Gordo, Floyd, and Mitchell counties presented the county social services project plan. He reviewed the mission, vision, and values of the project. He reviewed three project initiatives that summarize the actions of the project.

The first initiative is the integration of the pilot project counties' mental health and disability services central point of coordination (CPC) administration into the community mental health center (CMHC) system. The idea is that the CMHC is best equipped to manage the mental health services of the community while the CPC role should be administrative. There have been efficiencies in sharing information technology and sharing information at least on the local level to benefit clients.

The second project initiative is to build institutional services within the community to fill out the service system and reduce usage of the state-run institutional system. This action entails resetting the balance in the public and private portions of the service system. The institutions are needed to address high-risk needs, and currently the only other option for high-risk individuals are jails and hospitals.

The third initiative is to pool dollars, administration, infrastructure, and enrollees. The goal is to provide one funding stream and one service plan across a five-county region; to organize administrative staff around functional skill sets rather than geographic location; to reduce clerical processes that do not bring value to the system; to eliminate the need

for legal settlement; to produce outcome measures to improve quality and efficiency; and to provide for coordination of community services that is more timely for clients.

Pilot Project Challenges. Mr. Lincoln described the process used in creating the pilot project, from passage of legislation in 2008 to the present. Although the project began with the potential of involving 12 or more counties, the resulting project includes five counties. The project formed a legal partnership called County Social Services, established January 1, 2009. The pilot project considered using a Code Chapter 28E agreement to form a new legal entity but concluded that such things such as having county employees resign to work for the new entity were not feasible and that a joint sharing agreement was the best approach. They have found that sharing does not automatically save money and that sharing is not easy. Successful sharing requires unanimous consent of elected officials in support of the project as the best way to serve their constituents and overcoming the fear of county employees to join the effort.

Mr. Lincoln summarized the needs of the MH/DD system, noting that the DHS Division has identified three areas of improvement that are consistent with the consortium: expanding access to mental health services for children; providing for a statewide mental health emergency response system; and integrating the system of care to deliver quality evidence-based care regardless of age, race, disability, level of poverty, or co-occurring conditions.

Partnership Elements. Mr. Lincoln identified the elements essential for effective collaboration. The elements include: approval from each county board of supervisors of an easy-to-understand partnership agreement; committing all funds in the county's mental health account and state funds to the effort; placing all the relevant county employees under the consortium's administrator; supporting the role of the community mental health centers; reorganizing staff to align with the functional needs of the consortium; pooling dollars to simplify money management; moving the county-operated Medicaid-reimbursed agencies out of the combined fund; and providing a way for the counties to terminate participation.

Future Possibilities. Going forward, Mr. Lincoln proposed that if DHS chose to outsource capitated contracts for the delivery of MH/DD services, counties would need to regionalize to provide sufficient covered lives to underwrite the risk of a capitated contract. The pilot project counties believe this would deliver the outcomes and address many of the issues currently frustrating stakeholders.

Discussion. The workgroup discussed what the recommendation would be regarding continuing or expanding the use of this type of pilot. Some were concerned that the pilot did not seem to save money, even though efficiencies and redistribution of funds from administrative services to service delivery were realized, access to services was equalized, and a broader array of services was made available.

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ADULT MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICE SYSTEM STAKEHOLDER TASK FORCE WORK GROUP

August 26, 2009

Background. The legislation, (2009 Iowa Acts, H.F. 811 Sec. 56) requires the Co-chairpersons (Senator Jack Hatch and Representative Lisa Heddens) to consult with the ranking members (Senator David Johnson and Representative Dave Heaton) of the Joint Appropriations Subcommittee on Health and Human Services in appointing a task force of stakeholders for the 2009 Legislative Interim to address both funding and services issues associated with the service system administered by counties for adult mental health and developmental disabilities services and report recommendations to the Governor and the General Assembly for action during the 2010 Legislative Session. Due to the current budget situation and funding limitations, the chairpersons and ranking members asked the members of the Joint Subcommittee, particularly those who served on the two related subcommittees during the 2009 Session, to serve as the task force and hold one meeting during the late fall to receive recommendations from a stakeholder work group, formed and facilitated by legislative staff, to develop materials and options and receive input from those interested in MH/DD services for discussion and review at the task force meeting.

Membership. Membership of the stakeholder work group consists of two provider representatives, three representatives of the Iowa State Association of Counties, three representatives of the Department of Human Services (DHS), two representatives of consumers/advocates, and staff representing the House and Senate Democrat and Republican caucuses and nonpartisan staff. Legislators who are members of the task force as well as those with an interest in the stakeholder work group were invited to attend the work group meetings.

Work Group Organization. Following welcoming remarks by Senators Jack Hatch and Amanda Ragan, and member introductions, the work group agreed to operating ground rules including using a consensus approach for decision making. The work group utilized a background information memo during its discussion, available from the task force's

Internet page.

Work Group Tasks. The work group discussed the tasks specified by Co-chairpersons Hatch and Heddens to develop short-term and long-term options for reforming the adult MH/DD services system and funding. For the short term, the goal is to provide options to address funding eligibility, distribution, and other elements for the allowed growth and risk pool funding; and for the long-term, the goal is to provide options for pilot projects that will use existing funding more efficiently and allow testing of new options. The members discussed the need to focus both on services and funding in developing short-term and long-term reform options.

Current Environment. The work group reviewed the description of the current environment as described in the background memo. The memo describes state and county funding responsibilities, inadequacy of funding, the need for waiting lists, declining revenue projections, and the inequities among the counties relating to funding, levy rates and availability of services. The work group discussed the need to simplify the system with regard to funding and service delivery, the need for vertical and horizontal integration of the system, and the need to base the system on core principles and values that drive the development of services, rather than the funding streams and their corresponding services driving the system.

Some of the issues reviewed by the work group included:

- Would restructuring the administration of the system reduce costs? Examples include combining central points of coordination or regionalization of services. Many states have restructured the administration of the system to reduce costs, instead of first determining what persons with disabilities need and then building the delivery system to fit these needs.
- Are there savings in other areas that result from providing effective MH/DD services such as reduction in jail and prison time, avoidance of utilization of emergency rooms, etc. There is a need to look at overall outcomes, not just MH/DD system expenditures.
- Are there other services that can be provided through the Medicaid program in order to obtain federal financial participation? There are tradeoffs in this approach, including loss of flexibility and increased requirements such as statewide uniformity, documentation, and auditing.
- DHS is developing a comprehensive MH/DD system plan which includes defining principles, and completing a population-based needs assessment. Based on this assessment, models can be built to determine cost. DHS will share the time frame for progress of the comprehensive plan with the work group.
- Will substance abuse be included in the discussion?
- Medicaid home and community-based services recipients sometimes also receive other sources of financial support such as social security's Supplemental Security Income (SSI) program. Could these other sources be tapped to reduce costs to the MH/DD system?
- What is a base level of services? There is no definition of "core services." Many prior attempts at defining core services have failed because some believe "core services" would become the minimum set while others fear they would become the only services offered. Some like the idea of defining core principles and values rather than core services, and focusing on individual outcomes.
- There is a philosophical disagreement among counties as to the appropriate amount of services to be made available. Attitudes differ at the local level.
- How does the work group define the term "system" for its purposes?

Data and Information Needs. The work group compiled a list of initial data and informational needs that is posted on the task force web page.

Work Group Task Proposals.

With regard to the task of providing options to address the formulas for distribution of allowed growth and risk pool funding, the work group suggested:

- Addressing the year-end fund balance requirements so that counties are held harmless from the temporary federal medical assistance percentage (FMAP) increase, which could include choosing a prior year-ending balance or disregarding the portion of the ending balance attributable to the increased FMAP.
- Addressing the fund balance percentage amount used to determine county eligibility for funding.
- Other ideas should be emailed to staff for distribution prior to the next meeting.
- With regard to the task of providing options for pilot projects to reform the system in the long term, the work group suggested:
- Hearing a report on the pilot regionalization project underway in North Central counties.
- Constructing a system that determines what the best outcomes are and then developing services to attain these outcomes.

- Reviewing a case rate system. Possibly Dr. Flaum (a psychiatrist who directs the Iowa Consortium for Mental Health through the Department of Psychiatry at the University of Iowa) and others have information about this. Wright County utilizes an approach to allow individualized decision making at the individual/provider level. Polk County has a more individualized system.
- Continuing efforts to reduce overutilization of institutional care, including usage of an intermediate care facility for persons with mental retardation (ICF/MR) level of care offered by the State Resource Centers and private providers. Possibly expand the Money-Follows-the-Person program.

Next Meeting. The next meeting of the work group will be held on September 23, 2009, and the meeting tentatively scheduled for September 9, 2009, was canceled.

Internet Page: http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=502

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